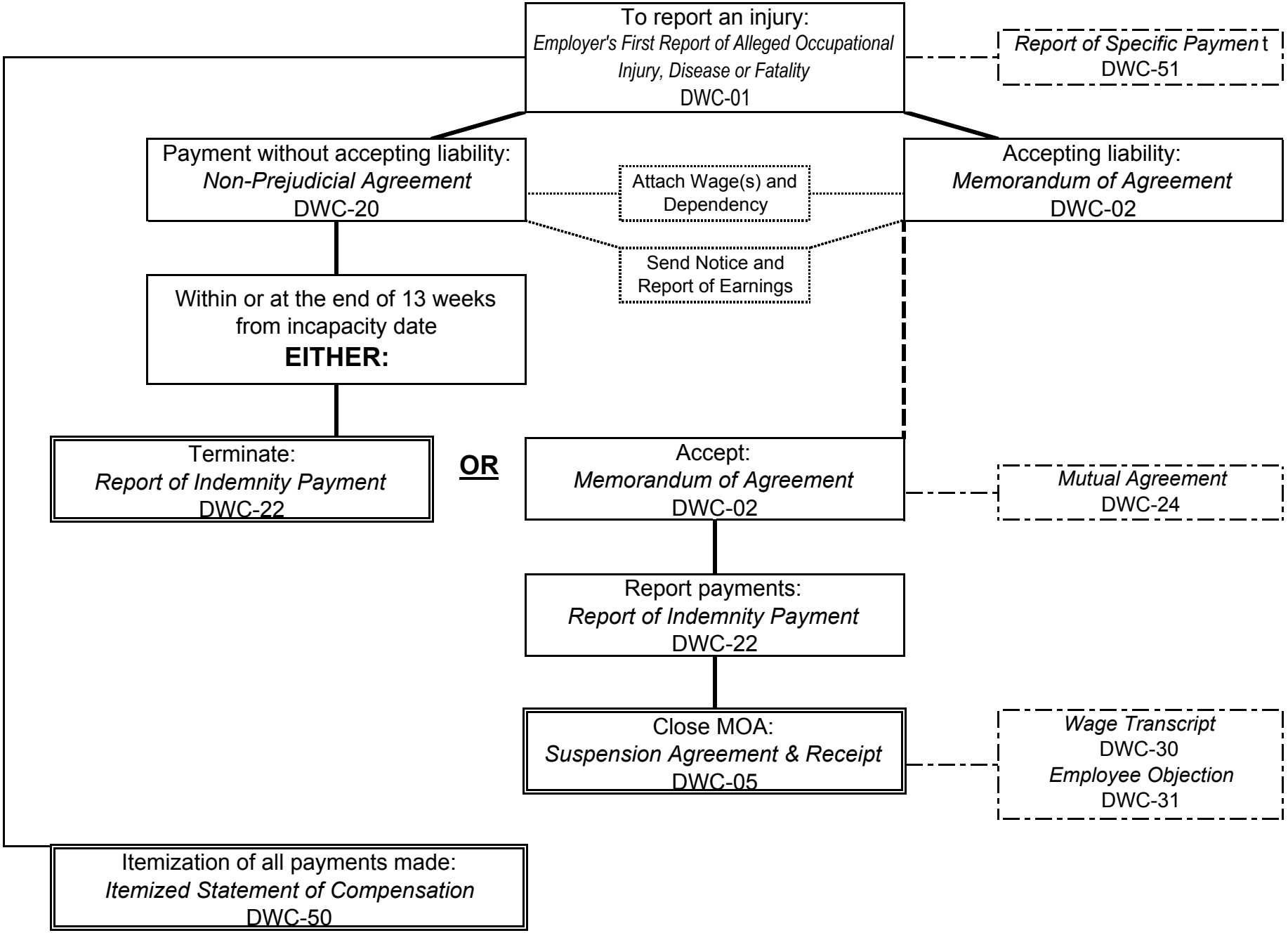
Sample Forms

The following sample represents one type of claim that, initially, does not accept liability by using a Non-Prejudicial Agreement. The claim then accepts liability with a Memorandum of Agreement. Please understand that when a claim is closed without accepting liability, you will use a Report of Indemnity Payment (DWC-22) with the *Termination of Benefits under Non-Prejudical Agreement* box checked.

This representation is meant to give you a sample of what various forms should look like when completed. Please refer to the Flow Chart and individual form instructions for more information.


To report an injury:
Employer's First Report of Alleged Occupational Injury, Disease or Fatality
DWC-01
Report of Specific Payment
DWC-51
Payment without accepting liability:
Non-Prejudicial Agreement
DWC-20
Attach Wage(s) and Dependency
Accepting liability:
Memorandum of Agreement
DWC-02
Send Notice and Report of Earnings
Within or at the end of 13 weeks from incapacity date
EITHER:
Terminate:
Report of Indemnity Payment
DWC-22
OR
Accept:
Memorandum of Agreement
DWC-02
Mutual Agreement
DWC-24
Report payments:
Report of Indemnity Payment
DWC-22
Close MOA:
Suspension Agreement & Receipt
DWC-05
Wage Transcript
DWC-30
Employee Objection
DWC-31
Itemization of all payments made:
Itemized Statement of Compensation
DWC-50

State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYER LOCATION:

FEIN 05-1234567
Name ABC, Incorporated
Address 222 Main Street
City, State, Zip Pleasantville, RI 02000
Phone (401) 555-1000 Ext. 333 Type of Business Costume Jewelry Mfg.
RI Unemployment Ins. No. 0007654321 NAICS 339914

2. EMPLOYER NAMED ON WC INSURANCE POLICY: ☐ SAME AS BLOCK 1

FEIN
Name
Address
City, State, Zip
Phone Ext.
WC Policy Number 0000098765

If there is a company other than who is listed in Block 1 that is the employer named on the WC policy (ex: parent company), you must complete this entire section. If it is the same as Block 1, simply check the appropriate box in this section -- IN EITHER CASE, list the WC policy number.

3. INSURANCE COMPANY NAMED ON WC POLICY:

FEIN 05-2727272
Name Proper Insurance Company
Address 333 Oak Road
Address Suite 001
City, State, Zip Wherever, RI 02000
Phone (401) 555-0001 Ext. 456

Note: Block 3 is for information on the actual insurance carrier named on the policy only.

4. CLAIM ADMINISTRATOR: ☐ SAME AS BLOCK 3

FEIN 05-111222333
Name XYZ Adjusting Company
Address 890 Elm Street, Suite 555
Address
City, State, Zip Somewhere, RI 02000
Phone (401) 555-1111 Ext.

5. EMPLOYEE INFORMATION:

SSN 123-45-6789 ☒ Male ☐ Female
Name O. Sean State
Address 123 Red Maple Lane
City, State, Zip Anytown, RI 02000
Phone (401) 555-1234 Date of Birth 01/01/1950
Occupation Shipping Mgr. Date Hired 3/3/2003
State of Hire Rhode Island
Preferred Language of Employee: X English O Spanish O Portuguese O Other:

6. MEDICAL INFORMATION:

Treatment Facility
Address
City, State, Zip
Phone Ext.

If this information is available, please be sure to include.

7. WITNESS INFORMATION:

Include if available.

Name Phone

8. INJURY INFORMATION:

Injury Date 7/1/2003
Time injury occurred 2:30 ☐ AM ☒ PM
Time employee began work 8:00 ☒ AM ☐ PM
1. First full day lost from work 7/2/2003 ☐ NONE LOST
2. Date returned to work (if appropriate)
3. Date employer notified of injury 7/1/2003
If fatal - **REPORT WITHIN 48 HOURS** - Date of death

What was person doing when injured?

Employee was loading boxes on a pallet when several boxes fell on top of him. Employee landed on left arm.

List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)

Broken Left Arm

Place where injury/illness occurred: ☒ At employer location listed in Block 1 **OR** Complete address where accident occurred:

Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☒ No

If Yes, date employer first notified of medical treatment or time lost

Category(ies) of injury or illness: X Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown

Print Name of Report Preparer	Date Prepared	Phone & Extension
Jane Smith	7/5/2003	(401) 555-1000 Ext. 333

Print Name of Employer Contact Person OR ☒ Same as above — Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

State of Rhode Island
NON-PREJUDICIAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE:		**2. EMPLOYER:**	
SSN	123-45-6789	FEIN	05-1234567
Name	O. Sean State	Name	ABC, Incorporated
Address	123 Red Maple Lane	Address	222 Main Street
Address		Address	
City, State, Zip	Anytown, RI 02000	City, State, Zip	Pleasantville, RI 02000
Phone	(401) 555-1234 Date of Birth 01/01/1950	Phone	(401) 555-1000 Ext. 333
3. INSURANCE COMPANY NAMED ON WC POLICY:		**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3	
FEIN	05-2727272	FEIN	05-111222333
Name	Proper Insurance Company	Name	XYZ Adjusting Company
Address	333 Oak Rd	Address	890 Elm Street, Suite 555
Address	Suite 001	Address	
City, State, Zip	Wherever, RI 02000	City, State, Zip	Somewhere, RI 02000
Phone	(401) 555-0001 Ext. 456	Phone	(401) 555-1111 Ext. 555
RI License Number	0009876	RI License or Self-Insurance Number	001234

Block 3 is for information on the actual insurance carrier named on the policy.

Injury date:	7/1/2003
First date of first disability:	7/2/2003
Place where injury occurred:	Same as Block 2

List injured body parts and nature of injury:

Compound fracture of left forearm

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☒ Temporary Partial as of 7/2/2003

☐ Death Benefits/Date of Death _____

Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☒ Married

		Number of Exemptions	4
		AWW (include bonus/no OT)	$534.52
		Average Overtime Amount	$22.14
AWW including Overtime	$556.66	Number of Dependents	2
Spendable Base Wage	$494.67	Weekly Dependency Rate	N/A
Base Compensation Rate	$371.00	Total Weekly Rate	$371.00

7. DATE OF INITIAL PAYMENT: 7/15/2003

Does employee have other employers? ☐ Yes ☒ No If yes, attach a wage statement from each employer.

Is this a recurrence of a previous injury? ☐ Yes ☒ No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: *(Signature of Sally Seashell)* Date: 7/14/2003

Print Name: Sally Seashell

RI Adjuster License Number: (Do not use SSN - get another number from DBR)

Phone & Extension: (401) 555-1111 ext. 555

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

State of Rhode Island
EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE INFORMATION:

SSN 123-45-6789 ☒Male ☐Female
Name O. Sean State
Address 123 Red Maple Lane
City, State, Zip Anytown, RI 02000
Phone (401) 555-1234 Date of Birth 01/01/1950

2. CLAIM INFORMATION:

Employer ABC, Incorporated
Claim Administrator XYZ Adjusting Company
Address 890 Elm Street, Suite 555
City, State, Zip Somewhere, RI 02000
Date of Injury 07/01/2003 Date of Incapacity 07/02/2003

THE EMPLOYEE MUST COMPLETE ALL REQUIRED INFORMATION:

Please return this form to your employer's workers' compensation Claim Administrator. If they do not receive this completed form promptly, it may result in a delay of your claim.

3. MARITAL STATUS & EXEMPTION INFORMATION: (Needed to calculate your weekly compensation payment)

Were you married at the time of your injury? ☒Yes ☐No If Yes, Spouse Name: Hope State
If Yes, does your spouse work? ☒Yes ☐No Spouse SSN**: This is optional--see below

Please put an appropriate number in each box -- you are entitled to one exemption for yourself and one for your spouse.

Yourself	1
Spouse	1
Total Dependents Listed **Below**	2
Total Other	
Total Number of Exemptions (Add all of the above)	4

(**Other**: You may be entitled to additional exemptions if you or your spouse are over 65 or blind. Please contact your employer's workers' compensation Claim Administrator for further information)

4. DEPENDENT INFORMATION List each dependent child below. A dependent child includes:

- ~ Children under the age of eighteen living with you or whom you were required to support at the time of the injury
- ~ Children you support who are over eighteen but who are mentally or physically incapacitated from earning
- ~ Children under the age of twenty-three who are full-time students at an accredited educational facility

Dependent's Name:	Dependent's Date of Birth:	Dependent's Social Security Number:**	If over 18 and under 23, Full-Time Student?	
1. Violet State	02/02/1984	This is optional--see below	☒Yes	☐No
2. Bowen State	03/03/1989		☐Yes	☐No
3.			☐Yes	☐No
4.			☐Yes	☐No
5.			☐Yes	☐No
6.			☐Yes	☐No
7.			☐Yes	☐No
8.			☐Yes	☐No
9.			☐Yes	☐No
10.			☐Yes	☐No

Employee Signature: Date:

(Signature of O. Sean State) 07/07/2003

**** Completion of the Social Security Number for Spouse and Dependents is optional.**

Employee Note: **DO NOT return this form to the Department of Labor and Training - RETURN TO Claim Administrator**

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE INFORMATION:

SSN 123-45-6789
Name O. Sean State
Hired for 40 hours each week (☐ Approximate)
Are these supplemental wages? ☐ Yes ☒ No
If yes, supplemental employer name:
Maximum no. of exemptions 4 ☐ Single ☒ Married

2. CLAIM INFORMATION:

Employer ABC, Incorporated
Insurance Co. Proper Insurance Company
Claim Administrator XYZ Adjusting Company
Injury date 07/01/2003
Incapacity date 07/02/2003
Hire date 3/3/2003

3. EMPLOYED LESS THAN 2 WEEKS:

If Yes:		**OR:**	
1. List agreed upon hourly wage			
2. Number of hrs. per week for full-time employees		Give average weekly for same or similar employment:	
3. Multiply #1 by #2 for average weekly wage			

4. EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1	6/28/2003	38	560.88
2	6/21/2003	VAC	UNPAID
3	6/14/2003	10	147.60
4	6/7/2003	44 NO OT	649.44
5	5/31/2003	40	590.40
6	5/24/2003	40	590.40
7	5/17/2003	SICK	590.40
8	5/10/2003	16	236.16
9	5/3/2003	VAC	300.00
10	4/26/2003	32	472.32
11	4/19/2003	0	0.00
12	4/12/2003	32	472.32
13	4/5/2003	40	590.40
Total number usable weeks:	11	Total earnings:	$5,200.32

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1: 17
Total **BONUS amount paid** in past **52 weeks**	Block 2: $1,050.00
Divide Block 2 by Block 1 for average bonus	Block 3: $61.76
Total **OVERTIME amount paid** in past **52 weeks**	Block 4: $376.38
Divide Block 4 by Block 1 for average overtime	Block 5: $22.14

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	$5,200.32
2. Total number usable weeks	11
3. Divide total earnings by number of usable weeks	$472.76
4. Average bonus (Block 3 in BONUS AND OT)	$61.76
5. Add 3 and 4 for AWW excluding Overtime	$534.52
6. Average overtime (Block 5 in BONUS AND OT)	$22.14
7. Add 5 and 6 for Total Average Weekly Wage	$556.66

Print Preparer Name:	Date:	Print Adjuster Name:	Date:
John Doe	7/7/2003	Sally Seashell	7/11/2003

State of Rhode Island
MEMORANDUM OF AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE:		**2. EMPLOYER:**	
SSN	123-45-6789	FEIN	05-1234567
Name	O. Sean State	Name	ABC, Incorporated
Address	123 Red Maple Lane	Address	222 Main Street
Address		Address	
City, State, Zip	Anytown, RI 02000	City, State, Zip	Pleasantville, RI 02000
Phone	(401) 555-1234 Date of Birth 01/01/1950	Phone	(401) 555-1000 Ext. 333
3. INSURANCE COMPANY NAMED ON WC POLICY:		**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3	
FEIN	05-2727272	FEIN	05-111222333
Name	Proper Insurance Company	Name	XYZ Adjusting Company
Address	333 Oak Rd	Address	890 Elm Street, Suite 555
Address	Suite 001	Address	
City, State, Zip	Wherever, RI 02000	City, State, Zip	Somewhere, RI 02000
Phone	(401) 555-0001 Ext. 456	Phone	(401) 555-1111 Ext. 555
RI License Number	0009876	RI License or Self-Insurance Number	001234

Block 3 is for information on the actual insurance carrier named on the policy.

Injury date:	7/1/2003
First date of first disability:	7/2/2003
Place where injury occurred:	Same as Block 2

List injured body parts and nature of injury:

Compound fracture of left forearm

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☒ Temporary Partial as of 7/2/2003

☐ Death Benefits/Date of Death _____

Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☒ Married

		Number of Exemptions	4
		AWW (include bonus/no OT)	$534.52
		Average Overtime Amount	$22.14
AWW including Overtime	$556.66	Number of Dependents	2
Spendable Base Wage	$494.67	Weekly Dependency Rate	N/A
Base Compensation Rate	$371.00	Total Weekly Rate	$371.00

7. DATE OF INITIAL PAYMENT UNDER MOA: 7/25/2003

Does employee have other employers? ☐ Yes ☒ No If yes, attach a wage statement from each employer.

Is this a recurrence of a previous injury? ☐ Yes ☒ No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: *(Signature of Sally Seashell)* Date: 7/25/2003

Print Name: Sally Seashell

RI Adjuster License Number: (Do not use SSN - get another number from DBR)

Phone & Extension: (401) 555-1111 ext. 555

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

State of Rhode Island
REPORT OF INDEMNITY PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:	YOU ***MUST*** CHECK ONE OF THE FOLLOWING:
☐ **TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT***	**Report type:** ☒ **INTERIM** ☐ **FINAL**
☒ **PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE**	**If FINAL**, date of last weekly indemnity payment:

1. EMPLOYEE INFORMATION:

SSN	123-45-6789
Name	O. Sean State
Address	123 Red Maple Lane
City, State, Zip	Anytown, RI 02000
Phone	(401) 555-1234 Date of Birth 01/01/1950
Maximum no. of exemptions	4 ☐ Single ☒ Married

2. CLAIM INFORMATION:

Employer	ABC, Incorporated
Insurance Co.	Proper Insurance Company
Claim Administrato	XYZ Adjusting Company
Injury date	07/01/2003
Incapacity date	07/02/2003
Date of death	☐ NOT work-related

3. RATE INFORMATION:

AWW including Overtime	$556.66	AWW (include bonus/no OT)	$534.52
Spendable Base Wage	$494.67	Total Cost of Living Adjustment(s)	N/A
Base Compensation Rate	$371.00	Weekly Dependency Rate	$371.00

4. WEEKLY COMPENSATION:

Indicate Payment Type	Payment period Date from	Payment period Date through	Number of Weeks & Days	Total Weekly Rate	Variable Partial Total Spendable	Compensation Paid	☐ Settlement ☐ Deny&Dismiss
☐TI ☒PI ☐DB	7/2/2003	7/23/2003	2 weeks 5 days	$371.00		$1,007.00	Amount:
☐TI ☐PI ☐DB							Decree No.
☐TI ☐PI ☐DB							Decree Date

5. WEEKLY COMPENSATION for Variable Partial Payments: (Complete information above also)

Week Ending	Gross Earnings	Spendable Earnings	Amount Paid	Week Ending	Gross Earnings	Spendable Earnings	Amount Paid

Signature: *(Signature of Sally Seashell)* Date: 7/25/2003

Print Name: Sally Seashell

RI Adjuster License Number: (Do not use SSN - get another number from DBR)

Phone & Extension: (401) 555-1111 ext. 555

***THE FOLLOWING NOTICE IS FOR EMPLOYEES TERMINATED UNDER A NON-PREJUDICIAL AGREEMENT ONLY**

Weekly compensation payments have stopped. The insurer/employer has not accepted liability for this claim. If you wish to protect any rights you may have under the Workers' Compensation Act, including possible entitlement to continued or future weekly compensation payments or payment of medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years from the first date of incapacity.

State of Rhode Island
REPORT OF INDEMNITY PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:	YOU ***MUST*** CHECK ONE OF THE FOLLOWING:
☐ **TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT***	**Report type:** ☐ **INTERIM** ☒ **FINAL**
☒ **PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE**	**If FINAL**, date of last weekly indemnity payment: 8/19/2003

1. EMPLOYEE INFORMATION:

SSN	123-45-6789
Name	O. Sean State
Address	123 Red Maple Lane
City, State, Zip	Anytown, RI 02000
Phone	(401) 555-1234 Date of Birth 01/01/1950
Maximum no. of exemptions	4 ☐ Single ☒ Married

2. CLAIM INFORMATION:

Employer	ABC, Incorporated
Insurance Co.	Proper Insurance Company
Claim Administrato	XYZ Adjusting Company
Injury date	07/01/2003
Incapacity date	07/02/2003
Date of death	☐ NOT work-related

3. RATE INFORMATION:

AWW including Overtime	$556.66	AWW (include bonus/no OT)	$534.52
Spendable Base Wage	$494.67	Total Cost of Living Adjustment(s)	N/A
Base Compensation Rate	$371.00	Weekly Dependency Rate	$371.00

4. WEEKLY COMPENSATION:

Indicate Payment Type	Payment period Date from	Payment period Date through	Number of Weeks & Days	Total Weekly Rate	Variable Partial Total Spendable	Compensation Paid	☐ Settlement ☐ Deny&Dismiss
☐TI ☒PI ☐DB	7/24/2003	7/30/2003	1 week	$371.00		$371.00	Amount:
☐TI ☒PI ☐DB	7/31/2003	8/16/2003	2 wks/3 days		$664.44	$402.69	Decree No.
☐TI ☐PI ☐DB							Decree Date

5. WEEKLY COMPENSATION for Variable Partial Payments: (Complete information above also)

Week Ending	Gross Earnings	Spendable Earnings	Amount Paid	Week Ending	Gross Earnings	Spendable Earnings	Amount Paid
8/2/2003	$120.84	$113.50	$73.88				
8/9/2003	$223.49	$209.17	$214.13				
8/16/2003	$365.58	$341.77	$114.68				

Signature: *(Signature of Sally Seashell)* Date: 8/19/2003

Print Name: Sally Seashell

RI Adjuster License Number: (Do not use SSN - get another number from DBR)

Phone & Extension: (401) 555-1111 ext. 555

***THE FOLLOWING NOTICE IS FOR EMPLOYEES TERMINATED UNDER A NON-PREJUDICIAL AGREEMENT ONLY**

Weekly compensation payments have stopped. The insurer/employer has not accepted liability for this claim. If you wish to protect any rights you may have under the Workers' Compensation Act, including possible entitlement to continued or future weekly compensation payments or payment of medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years from the first date of incapacity.

State of Rhode Island
SUSPENSION AGREEMENT AND RECEIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

1. EMPLOYEE INFORMATION:

SSN	123-45-6789
Name	O. Sean State
Address	123 Red Maple Lane
City, State, Zip	Anytown, RI 02000
Phone	(401) 555-1234

2. CLAIM INFORMATION:

Employer	ABC, Incorporated
Insurance Co.	Proper Insurance Company
Claim Administrator	XYZ Adjusting Company
Injury date	07/01/2003
Incapacity date	07/02/2003

We agree that weekly compensation which began on July 2, 2003 (date of incapacity) will end as of August 16, 2003 (date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature: Date:

(Signature of O. Sean State) August 19, 2003

Employer/Insurer Signature: Date:

(Signature of Sally Seashell) August 19, 2003

State of Rhode Island
REPORT OF SPECIFIC PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. This number is assigned by DLT

Insurer File No. If the insurer has a file number, it can be put here.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:

☒ **LOST TIME** ☐ **NO LOST TIME** ☐ **FEDERAL JURISDICTION**

1. EMPLOYEE:

SSN	123-45-6789
Name	O. Sean State
Address	123 Red Maple Lane
Address	
City, State, Zip	Anytown, RI 02000
Phone	(401) 555-1234 Date of Birth 01/01/1950

2. EMPLOYER:

FEIN	05-1234567
Name	ABC, Incorporated
Address	222 Main Street
Address	
City, State, Zip	Pleasantville, RI 02000
Phone	(401) 555-1000 Ext. 333

3. INSURANCE COMPANY NAMED ON WC POLICY:

FEIN	05-2727272
Name	Proper Insurance Company
Address	333 Oak Rd
Address	Suite 001
City, State, Zip	Wherever, RI 02000
Phone	(401) 555-0001 Ext. 456
RI License Number	0009876

Block 3 is for information on the actual insurance carrier named on the policy.

4. CLAIM ADMINISTRATOR: ☐ **SAME AS BLOCK 3**

FEIN	05-111222333
Name	XYZ Adjusting Company
Address	890 Elm Street, Suite 555
Address	
City, State, Zip	Somewhere, RI 02000
Phone	(401) 555-1111 Ext. 555
RI License or Self-Insurance Number	001234

5. CLAIM INFORMATION:

Injury date 7/1/2003 Incapacity date (if appropriate) 7/2/2003

Average Weekly Wage(including OT) $556.66 Weekly Specific Rate $90.00

Specific paid by: ☐ Court Order Date: Number: **OR** ☒ Agreement of the Parties

Description of Injury/Specific: 3 inch scar to left forearm

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
☒ disfigurement ☐ loss of use	Left Arm		30	$2,700.00	11/20/2003
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					

Hearing Loss			Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			
Right Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			

Employee Signature: (optional)	Date:	Employer/Insurer Signature:	Date:
(Signature of O. Sean State)	11/20/2003	*(Signature of Sally Seashell)*	11/20/2003